Manhattanville College International Student Accident and Sickness Insurance Waiver Application

Annual Term (8/1/2014 – 7/31/2015)

A Completed Waiver Application Form with Required Documentation must be

Postmarked by Monday, September 16, 2014. There are no exceptions.

Mandatory Coverage Period: August 1, 2014 - July 31, 2015

Student Information (Required) ***PLEASE PRINT***

Student Last Name *First* *Middle* *Student ID #*

Street Address or POB *City* *State* *ZIP Code*

( )

Phone # with area code *Email Address* *Birth Date*

Manhattanville College requires all F1 international students to maintain approved comprehensive U.S. based health insurance coverage while enrolled at the College. Enrollment in the College sponsored health plan is automatic when an international student registers for classes and the cost of the policy will appear on the tuition and fee bill. However, the fee shall be waived if a student completes the waiver form and provides acceptable evidence of continuing coverage in a plan meeting the following standards.

Waiver requests are required to meet ALL of the following minimum requirements:

- ☐ Medical benefits of at least $50,000 per accident or illness
- ☐ Repatriation of remains in the amount of $7,500
- ☐ Expenses associated with the medical evacuation of the exchange visitor to his or her home country in the amount of $10,000
- ☐ A Deductible not to exceed $500 per accident or illness
- ☐ U.S. based Insurance must be effect during the period of time you are enrolled in Manhattanville College's International Program.

In addition, your policy, plan, or contract must meet at least ONE of the following requirements (See 22 CFR 62.14 for more information):

- ☐ Underwritten by an insurance corporation having an A.M. Best rating of "A-" or above, an Insurance Solvency International, Ltd. (ISI) rating of "A-i" or above, a Standard & Poor's Claims-paying Ability rating of "A-" or above, a Weiss Research, Inc. rating of B+ or above, or such other rating as the Department of State may from time to time specify; or
- ☐ Backed by the full faith and credit of the government of the exchange visitor's home country; or
- ☐ Part of a health benefits program offered on a group basis to employees or enrolled students by a designated sponsor; or
- ☐ Offered through or underwritten by a federally qualified Health Maintenance Organization (HMO) or eligible Competitive Medical Plan (CMP) as determined by the Health Care Financing Administration of the U.S. Department of Health and Human Services.

Each of the following points of information must be provided in order to waive enrollment:

Name of Insurance Company or Health Plan _____

Address of Insurance Company: _____ City: _____ State: _____ Zip: _____

Member ID# _____ Group ID# _____ Phone Number to Verify Coverage: _____

Name of Primary Insured: _____

Address of Primary Insured: _____ City: _____ State: _____ Zip: _____

Name of employer providing coverage (if coverage is from an employer-sponsored health plan): _____

Address of employer providing coverage: _____ City: _____ State: _____ Zip: _____

I am providing the following documentation with this form that identifies me as a covered individual, provides the start and end dates of continuing coverage for the entire mandatory coverage period and clearly indicates that the coverage meets or exceeds the minimum requirements listed above, including coverage amounts in US dollars.

- ☐ The front and back of my insurance card and/or
- ☐ A copy of the summary of benefits and/or
- ☐ A letter on company letterhead written in English

Please read and check the box acknowledging that you have read and understand.

☐ I certify that my current U.S. based health insurance coverage meets or exceeds the above listed minimum coverage. I understand that the sole purpose of Manhattanville College's review of this information is to determine if I qualify for a waiver of enrollment in the Student Accident and Sickness plan. I understand that Manhattanville College's review and/or approval of this application does not constitute a determination by Manhattanville College as to the adequacy of this coverage for any purpose. I certify that my U.S. based health insurance coverage is in effect and will remain in effect for the entire Manhattanville College Student Accident and Sickness Insurance coverage period for the semester for which I am requesting this waiver. I understand that it is my sole responsibility to maintain the minimum coverage required by applicable federal regulations. I further understand that failure to maintain comparable coverage upon which a waiver is granted is a violation of College policy and failure by certain visa holders to maintain the required minimum will be reported to the appropriated authorities and my result in revocation of the visa by the U.S. State Department. I certify that I am legally responsible for my own medical expenses and that Manhattanville College is not responsible for such expenses.

Student's signature _____ Date _____

Parent's signature _____ Date _____

(Parent(s) must sign for students who are under age 18.)

Return your completed form and documentation to:
Consolidated Health Plans – 2077 Roosevelt Avenue – Springfield, MA 01104 – Attn: Enrollment Dept.
Fax: (413) 214-6785 or Email: enrollment@chpemail.com